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Beneficiary Complaints: How to Respond to Appeals, Grievances and Redeterminations

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Session Overview

- Part D Sponsor Responsibilities
- Appeals & Grievances – Common issues, challenges and mistakes
- Part D CMS Audit Guide Elements
- Part D Reporting Requirements
- Appeals & Grievances Case Study
- Appendix
  - Key Terms
  - MA-PD and PDP Audit Guide Elements
  - CY 2008 Medicare Part D Reporting Requirements
  - References

Session Objectives

- Gain a detailed understanding of the Medicare Part D Appeals & Grievances process as well as other processes related to Part D Plan Sponsors' responsibilities in responding to beneficiary complaints
- Gain a detailed understanding of the CMS MA-PD and PDP Audit Guide data elements related to Appeals & Grievances, Determinations and Redeterminations
- Develop a detailed understanding of the Medicare Part D Reporting Requirements related to Appeals & Grievances, Determinations and Redeterminations

Part D Sponsor Responsibilities

- Establishing and maintaining procedures for:
  - Standard and expedited coverage determinations
  - Standard and expedited appeals (redeterminations); and
  - Standard and expedited grievances

Part D Sponsor Responsibilities

- Providing written information to enrollees about the grievances and appeals procedures at the following times:
  - Grievance Procedure: at initial enrollment, upon involuntary disenrollment initiated by the Part D sponsor, upon denial of an enrollee's request for an expedited review, upon an enrollee's request and annually thereafter;
  - Appeals Procedure: at initial enrollment, upon notification of an adverse coverage determination or denial, upon notification of a service or coverage termination, changes to formulary or cost-sharing status, and annually thereafter; and
  - Quality of Care complaint process (under QIO process): at initial enrollment and annually thereafter

Common Issues, Challenges and Mistakes Previously Identified or Reported by CMS via the CAP website

- Misclassification of complaints, grievances, coverage determinations and appeals
  - Correct classification and categorization of complaints vs grievances vs inquiries
- Complaints that are both grievances and coverage determinations
  - Complaints that have both a grievance and a determination/redetermination request should be processed separately
- Appointed Representative: verification and rights
  - Appointment of Representative – Form CMS-1696

Common Issues, Challenges and Mistakes Previously Identified or Reported by CMS via the CAP website (cont.)

- Beneficiary Notification – timeliness and content
  - Standard vs Expedited
  - Oral vs Written notification
  - Notice Content – clear, concise, and specific language
- Beneficiary Notification – Parties
  - Enrollee
  - Prescribing Physician
  - Authorized Representative

Common Issues, Challenges and Mistakes Previously Identified or Reported by CMS via the CAP website (cont.)

- Processing expedited coverage determinations and redeterminations
  - Prescribing physicians cannot request standard redeterminations
  - Good Cause Extensions
  - Oral/Written Notification
- Processing oral coverage determinations and redeterminations
  - Oral requests should be documented in writing in the enrollee's own words, repeated back to the enrollee to confirm the accuracy, and placed into a tracking system for timely processing

Common Issues, Challenges and Mistakes Previously Identified or Reported by CMS via the CAP website (cont.)

- Forwarding cases not processed timely to the IRE
  - Timely forwarding to IRE with complete supporting case file documentation
  - Timely notification to enrollee of forwarding to IRE
- Formulary exceptions, cost sharing, and tiering requests
  - Clearly documented criteria
  - Documentation of criteria used to support decision
  - Process for requesting supporting statement/medical record documentation of medical necessity or exception/tiering request

New Privacy Requirements

- As of January 1, 2009, the Independent Review Entity (IRE) will implement a new format for all correspondence sent to Medicare beneficiaries
- The new format will include the first initial of the beneficiary's first name, the beneficiary's full last name and the last four digits of the beneficiary's health insurance claim number (HICN)
  - The IRE may consider using additional data points (e.g. DOB, plan member ID)
- Part D plan sponsors should ensure their systems and operations can track and process appeals using the new format

Appeals & Grievances Timelines

Area	Timelines
Filing an Appeal / Grievance / Request for IRE review or Higher Level Review	**60 days from date of decision/notice**
Coverage Determination Decision	**Standard Process: 72 hour time limit*** **Expedited Process: 24 hour time limit***
Redetermination Decision	**Standard Redetermination: 7 day time limit*** **Expedited Redetermination: 72 hour time limit***
IRE Review (Second Level of Appeal)	**Standard Reconsideration: 7 day time limit** **Expedited Reconsideration: 72 hour time limit**

* A Part D plan sponsor must notify the enrollee of its determination/redetermination as expeditiously as the enrollee's health condition requires but no later than the statutory timelines

Appeals & Grievances Timelines

Area	Timelines
Administrative Law Judge (ALJ) Review	**No statutory time limit for processing***
Medicare Appeals Council (MAC) Review	**No statutory time limit for processing**
Federal District Court	**No statutory time limit for processing***

*The Amount In Controversy (AIC) requirement for an ALJ hearing and Federal District Court are adjusted in accordance with the medical care component of the consumer price index

Appeals & Grievances - Examples

Complaints may include both appeals and grievances. A Part D sponsor must determine if the issues in an enrollee's complaint meet the definition of an appeal or grievance or both.

Example	Appeal	Grievance
Complaint about co-payments	X	X
• An enrollee expresses general dissatisfaction about a co-payment amount.		X
• An enrollee believes that a Part D sponsor has required the enrollee to pay an amount for a drug that should be the sponsor's responsibility.	X	
A request by a member to continue to take his/her high cholesterol medication that he/she has taken for years but the medication is not a part of the plan's Part D formulary.	N/A	N/A
A complaint by an enrollee who is upset that a specialist that he/she currently uses will no longer be a contracted provider.	X	X
A complaint about a denial of an enrollee's request for an expedited coverage determination.	X	

Examples (Cont.)

Complaints may include both appeals and grievances. A Part D sponsor must determine if the issues in an enrollee's complaint meet the definition of an appeal or grievance or both.

Example	Appeal	Grievance
An enrollee calls to complain that it has been two weeks since he/she filed a request for a drug coverage determination but has not received a decision from the plan sponsor regarding the determination request.		X
An enrollee generally fills his prescriptions via mail order but encounters problems with the online pharmacy's website and decides to go to a non-network walk-in pharmacy. Because of the plan design, the enrollee has to pay a higher co-pay because he went to a non-network pharmacy and went to a walk-in pharmacy rather than mail-order. The enrollee calls the Part D sponsor complaining about the online pharmacy's website being down and requests that the sponsor reimburse the member for the difference in the co-pay.	X	X
A complaint by an enrollee that a drug that he/she is currently taking is not a part of the Part D sponsor's formulary.	X	X
An enrollee that wants to know if a drug that he/she is taking is a part of the plan's Part D formulary	N/A	N/A

Reporting Requirements / Common Issues

- 2009 reporting requirements will remain the same as the 2008 requirements
  - See the appendix for detailed requirements
- Common issues that lead to inaccurate reporting to CMS
  - Poor training and understanding of what an appeal and grievance is and their differences
  - Less than perfect tracking systems for appeals and grievances
    - Poor segregation and identification of appeals and grievance for reporting (and auditing purposes)
  - Several distinct areas within the Part D sponsor making decisions that affect coverage
    - Poor coordination of information between departments and entities such as pharmacies, medial management department, pharmacy department and appeals and grievance department

Case Study – Appeals & Grievances

- Mr. A has high cholesterol and has been taking Lipitor for the last 10 years. He has previously tried alternative lipid lowering drugs and statin class drugs but with no therapeutic success. He recently switched Part D plans and his new plan does not have Lipitor as a formulary drug.
- Mr. A's physician filed a standard coverage determination request for a formulary exception for Lipitor. There was no supporting statement or documentation submitted by the prescribing physician for medical necessity or failed formulary alternatives.

Case Study – Appeals & Grievances

- The plan denied the request stating Mr. A try a formulary drug. Mr. A's physician filed a standard redetermination request with the supporting statement of failed therapeutic success of formulary alternatives in the past but no copies of Mr. A's medical record.
- Two weeks passed and neither Mr. A nor his physician received a response from the plan sponsor. Mr. A's physician resubmitted the standard redetermination requesting a response because Mr. A only had a week's supply of medication left. One week later, the plan responded with a decision that reversed it's original coverage determination.

Case Study – A&G Issues

- Coverage Determination request
  - Prescribing physician requesting the coverage determination should submit a supporting statement of medical necessity or copies of medical records for exceptions or tiering requests.
- Processing Coverage Determination
  - Plan sponsor should attempt to contact the enrollee or prescribing physician requesting supporting statement or medical record documentation for exceptions and tiering requests before denying requests.

Case Study – A&G Issues (cont.)

- Redetermination – processing and filing
  - Prescribing physicians cannot request standard redeterminations.
  - Prescribing physician should have submitted copies of Mr. A's medical record with documentation of failed formulary alternatives along with the supporting statement.
  - The plan sponsor should have processed the first determination request as an expedited request or sent a letter to the enrollee and the member stating the request could not be processed because prescribing physicians cannot submit standard redetermination requests.
  - The plan sponsor should have forwarded the case to the IRE within 24 hours of the expiration of the timeframe.

Case Study – A&G Issues (cont.)

- Second Redetermination Request
  - The prescribing physician or the enrollee should have forwarded the case to the IRE rather than resubmitting the redetermination request.
  - The plan sponsor should not have made a decision on the second redetermination, instead forwarding the case to the IRE. But since, it did process the second request, it should have processed it as an expedited request instead of a standard redetermination because Mr. A only had one week's supply of medication left.

APPENDIX

Key Terms

- **Appeal -** Any of the procedures that deal with the review of adverse organization and coverage determinations on the health care services or Part D benefits an enrollee believes he or she is entitled to receive. These procedures include reconsiderations, redeterminations, reconsiderations by the independent review entity (IRE), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.
- **Complaint –** any expression of dissatisfaction to a Medicare health plan or Part D sponsor, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing; may involve a grievance, coverage/organization determination or both
- **Coverage Determination –** any decision made by or on behalf of a Part D sponsor regarding payment or benefits to which an enrollee believes he or she is entitled
- **Effectuation –** compliance with a partial or complete reversal of a Medicare health plan/Part D sponsor's original adverse coverage/organization determination. Compliance may entail payment of a claim, or authorization of a service or provision of services
- **Enrollee –** a MA or Part D eligible individual that that elected a MA or Part D plan
- **Grievance –** any complaint or dispute, other than one involving an organization/coverage determination, or an LIS or LEP determination, expressing dissatisfaction with the manner in which a Medicare health plan or Part D sponsor provides health care services, regardless of whether any remedial action can be taken

Key Terms – Cont.

- **Independent Review Entity (IRE) –** an independent entity contracted by CMS to review Medicare health plans' adverse reconsiderations of organization determinations and Part D sponsor denials of coverage determinations
- **Inquiry –** any oral or written request to a Medicare health plan/Part D sponsor, provider, facility, without an expression of dissatisfaction or a request for coverage determination/exception
- **Quality Improvement Organization (QIO) –** organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees
- **Reconsideration –** An enrollee's first step in the appeal process after an adverse organization determination; a Medicare health plan or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
- **Redetermination -** The first level of the appeal process, which involves a Part D plan sponsor reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained
- **Representative –** an individual appointed by an enrollee or other party to act on behalf of an enrollee or other party in any of the levels of the appeals and grievance process

Part D Audit Guide Elements

		MA-PD	PDP
Grievances			
	Organization Determinations and Reconsiderations Not Categorized as Grievances (Complaint Categorization)	X	X
	Grievance Adjudication		
	Grievance Decision Notification (Timeliness)	X	X
	Grievance Decision Notification (Notice Content)	X	X
	Method of Grievance Decision Notification (Response)	X	X
	Grievance Policies and Procedures	X	X
	Grievance Process Training	X	X
	Grievance Response - Quality of Care	X	X
	Timely Response to Expedited Grievances	X	X
Coverage Determinations			
	Notices in Network Pharmacies	X	X
	Coverage Determination Policies and procedures	X	X
	Timely Notification of Coverage Determination Concerning Drug Benefit	X	X
	Coverage Determinations Concerning Payment	X	X
	Denial Notice Requirements for Coverage Determinations	X	X
	Decision to Accept or Deny Request for Expedited Coverage Determination	X	X
	Timely Notification Following Decision to Deny Request for Expedited Coverage Determination	X	X
	Notice Content Requirements for Decision to Deny Request for Expedited Coverage Determination	X	X
	Timely Notification of Expedited Coverage Determination	X	X
	Notice Content Requirements for Expedited Coverage Determination	X	X

Part D Audit Guide Elements (Cont.)

		MA-PD	PDP
Exceptions			
	Exceptions Procedures and Criteria (Tiered Cost Sharing)	X	X
	Exceptions Procedures and Criteria (Non-Dormulary Drugs)	X	X
	Approval of Tiering and Non-Formulary Exceptions Requests	X	X
Redeterminations			
	Request for Redeterminations (Standard)	X	X
	Request for Redeterminations (Expedited)	X	X
	Decision to Accept or Deny Raquest for Expedited Redetermination	X	X
	Actions Following Decision to Deny Request for Expedited Redetermination	X	X
	Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit	X	X
	Timely Notification and Effectuation of Standard Redetermination Concerning Payment	X	X
	Timely Notification of Expedited Redetermination and Request for Medical Information	X	X
	Expedited Coverage Redetermination Reversals	X	X
	Review of Adverse Coverage Determinaitons	X	X
	Timely Transfer of IRE Upon Reconsideration Request	X	X
Reversals by Other Than Part D Sponsors			
	Effectuation of Third Party Reversals - Benefits (Standard)	X	X
	Effectuation of Third Party Reversals - Payments (Standard)	X	X
	Effectuation of Third Party Reversals - Benefits (Expedited)	X	X

Part D Reporting Requirements - Appeals

Area	Data Element Description
Appeals	A. The number of appeals submitted for **standard** redetermination in the time period specified above. (Do not include those appeals that were submitted as expedited redeterminations and were not granted expedited status.) B. The number of appeals submitted for **expedited** redetermination in the time period specified above. C. The number of appeals submitted for **expedited** redetermination that were granted **expedited** status in the time period specified above. D. The number of appeals submitted for **standard** redetermination withdrawn by the enrollee in the time period specified above. E. The number of appeals submitted for **expedited** redetermination withdrawn by the enrollee in the time period specified above. F. The number of redeterminations in the time period specified above resulting in full reversal of original decision. G. The number of redeterminations in the time period specified above resulting in partial reversal of original decision. H. The number of adverse redeterminations in the time period specified above due to insufficient evidence of medical necessity from enrollee's prescribing physician. Examples of insufficient evidence of medical necessity may include, but are not limited to, when the plan does not receive the information, or the information received does not support medical necessity.

Note: Reporting requirements for Appeals includes data for coverage determinations, redeterminations by the Plan and reconsiderations by the IRE.

Source: Medicare Part D Reporting Requirements CY 2008

Part D Reporting Requirements – Appeals Cont.

Area	Data Element Description
Appeals	I. The number of appeals submitted for IRE reconsideration in the time period specified above due to inability to meet timeframe for **coverage determination**. J. The number of appeals submitted for IRE reconsideration in the time period specified above due to inability to meet timeframe for **redetermination**. K. The number of IRE decisions for **standard** reconsideration in the time period specified above resulting in full reversal of original coverage determination or redetermination. L. The number of IRE decisions for **standard** reconsideration in the time period specified above resulting in partial reversal of original coverage determination or redetermination. M. The number of IRE decisions for **expedited** reconsideration in the time period specified above resulting in full reversal of original coverage determination or redetermination. N. The number of IRE decisions for **expedited** reconsideration in the time period specified above resulting in partial reversal of original coverage determination or redetermination. O. The number of IRE decisions for **standard** reconsideration in the time period specified above resulting in upholding of original coverage determination or redetermination. P. The number of IRE decisions for **expedited** reconsideration in the time period specified above resulting in upholding of original coverage determination or redetermination.

Note: Reporting requirements for Appeals includes data for coverage determinations, redeterminations by the Plan and reconsiderations by the IRE.

Source: Medicare Part D Reporting Requirements CY 2008

Part D Reporting Requirements - Grievances

Area	Data Element Description
Grievances	A. For the time period identified above, the number of fraud and abuse grievances received related to Part D. A fraud grievance is a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, Plan, Plan Agent or broker, or beneficiary engaged in the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. An abuse grievance is a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, Plan, Plan Agent or broker or beneficiary engaged in behavior that the individual should have known to be false, and the individual should have known that the deception could result in some unauthorized benefit to himself/herself or some other person. B. For the time period identified above, the number of enrollment/disenrollment grievances received related to Part D. Examples include, but are not limited to, discrimination in the enrollment process, enrollment information and/or identification cards not being received by beneficiaries in a timely manner, and disenrollment requests not being processed in a timely manner. C. For the time period identified above, the number of benefit package grievances received related to Part D. Examples include, but are not limited to, beneficiary cost sharing, pricing co-insurance issues and issues related to coverage during the coverage gap period. D. For the time period identified above, the number of pharmacy access/network grievances received related to Part D. Examples include, but are not limited to, network pharmacy refusing to accept a beneficiary's card and network/non-network pharmacy concerns. E. For the time period identified above, the number of marketing grievances received related to Part D. Examples include, but are not limited to, marketing materials or promotional messages by sales representatives that include misrepresentations or false/misleading information about plans and benefits, overly aggressive marketing practices, and discriminatory practices identified in marketing materials or through oral/written promotional messages.

Source: Medicare Part D Reporting Requirements CY 2008

Part D Reporting Requirements – Grievances Cont.

Area	Data Element Description
Grievances	E. For the time period identified above, the number of customer service grievances received related to Part D. Examples include, but are not limited to, grievances regarding services provided by the pharmacist/pharmacy staff, plan or subcontractor representatives, or customer service representatives. F. For the time period identified above, the number of confidentiality/privacy grievances received related to Part D. Examples include, but are not limited to, potential violations of medical information privacy standards by the plan or pharmacy. G. For the time period identified above, the number of quality of care grievances received related to Part D. Examples include, but are not limited to, grievances received from beneficiaries or Quality Improvement Organizations (QIOs) regarding quality of care. H. For the time period identified above, the number of exception grievances received related to Part D. An example of an exception grievance is one which is filed because an enrollee's request to have their coverage determination expedited was denied. I. For the time period identified above, the number of appeal grievances received related to Part D. An example of an appeal grievance is one which is filed because an enrollee's request to have a redetermination expedited was denied. J. For the time period identified above, the number of other grievances received related to Part D not falling into one of the categories described above. K. For the time period identified above, the total number of grievances received related to Part D. L. For the time period identified above, the total number of LIS grievances received related to Part D. This number should be based on the beneficiary's LIS status at the time of filing the grievance.

Source: Medicare Part D Reporting Requirements CY 2008

References

- **Medicare Managed Care Manual – Chapter 4 – Benefits and Beneficiary Protections**
- **Medicare Managed Care Manual – Chapter 11 – Medicare Advantage Application Procedures and Contract Requirements**
- **Prescription Drug Benefit Manual – Chapter 9 – Part D Program to Control Fraud, Waste, and Abuse**
- **Prescription Drug Benefit Manual – Chapter 18 – Part D Enrollee Grievances, Coverage Determinations and Appeals**
- **MA-PD Sponsor Part D Audit Guide Version 2.0**
- **PDP Sponsor Part D Audit Guide Version 2.0**
- **Medicare Part D Reporting Requirements CY 2008**
- **MA-PD Application CY 2009**
- **PDP Application CY 2009**
- **Part D Memo 2009 Readiness Checklist**
- **2009 Call Letter**

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